The common *ad hominem* argument is that the eighteenth-century medical moralists could not be real theoreticians or philosophers because they were so eminently practical men who wrote medical ethics which was chiefly concerned with practical, not theoretical, problems. This claim, shared by most historians of medical ethics, is never followed by an explanation as to why practical men could not also have pursued theoretical interests. The adherents of this view do not, moreover, explain what our three physicians themselves meant by the term 'practical', a point to which we shall return.

The critics' claim is puzzling because it is one which any history of the intellectual life of the Enlightenment would easily dispel. Physicians, even practising ones, were among the most prominent men of letters, scientists, novelists, poets and philosophers. As Maureen McNeil has recently observed, there was no other century when medical doctors played such a conspicuous cultural role.

> The literary scene was blessed with the contributions of medical men such as John Arbuthnot, John Aikin, Mark Akenside, Sir Richard Blackmore, Oliver Goldsmith and Tobias Smollett, while Dr Johnson carried the general public into the medical world with his 'Life of Boerhaave' in the *Gentleman's Magazine* of 1739. Eighteenth-century readers were informed about some contemporary theories of embryology and midwifery through Tristram Shandy's accounts of his own conception and birth. Dr Johnson regarded the field of medicine as significant enough to merit its own dictionary and he collaborated with Dr Robert James on such a project. Physicians also made their mark in the field of philosophy. John Locke, who wielded such a vital influence over the course of eighteenth-century philosophy, was medically trained, and Bishop Berkeley's pursuit of philosophical issues brought him to a consideration of medical matters in his *Treatise on Tar Water*. Into countless other fields the medically-trained ventured with remarkable success: Nehemiah Grew (1641–1712) into botany, George Fordyce (1736–1802) into agriculture, Hans Sloane (1660–1753) and John Hunter (1728–1793) into natural history, and James Hutton (1726–1797) into geology.[14]

Apart from the subject of McNeil's study, the physician, poet and scientist, Erasmus Darwin, men who were both philosophers and physicians, such as Bernard Mandeville, George Cheyne and David Hartley, could be added to this less than exhaustive list. Significantly, our physicians were familiar with the works of most of these men, and some of them were their teachers, classmates, colleagues, correspondents and intimate friends. In light of this, and

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the evidence that Gregory, Percival and Rush were themselves well-known contemporary authors, it seems more reasonable to assume the opposite of what the critics of medical ethics have suggested: that it would be most surprising if our physicians, like many of their medical contemporaries, did *not* combine their theoretical pursuits with their practical ones, and if their ethics did not reflect this combination.

The question of what might be the most judicious balance of practice and theory in the life of the professional man was discussed throughout the eighteenth century, as often as that of the relative merits of the active and contemplative life. Both topics played an important role in the tradition of moral philosophy within which I try to locate the three physicians.

The recent critics of early modern medical ethics use the term 'practical' in several ways. In some of the accounts we referred to, it was used to imply that physicians were extremely busy men and, being so, had neither the time nor the inclination for theoretical interests. The term 'practical' is thus used to evoke the hard-working physician who adopts a no-nonsense approach to problems and has no time for 'vague ethical generalities', as it was expressed. In other accounts, the term 'practical' connotes a less ingenuous medical type: the physician who perceives a threat to his tribe through competition and who therefore sets out to write a tract arguing for the privileges and rights owed to his profession. Finally, there is the physician who is 'practical' in addressing the internal problems of practice and producing a dreary "how-to" manual for the use of his colleagues. Neither the author nor his medical readers are, on this view, much concerned with matters of health and medicine *per se*. All these criticisms arise from a need to understand why the eighteenth-century medical ethicists did not address the problems that interest their twentieth-century successors and, particularly, from the idea that Percival spoilt the promising beginnings in Gregory. Since they did not address our theoretical issues, especially the nature of the physician–patient relationship, they must have been non-theoretical, purely practical men. By contrast, it is claimed, modern medical ethics or bioethics is a lively and accessible discussion of these important matters, and it is refreshed by the contributions of philosophers, lawyers and social scientists. To their contemporaries, however, Gregory, Percival and Rush were qualified to write medical ethics only because they were practical men of speculative bent. Not only did they have theoretical expertise in their own field but they were also practical moralists. All three men

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had, in fact, impeccable credentials for the job. All were reputable practising physicians, well-known teachers of medicine, acclaimed medical reformers, and Percival and Rush at least, active medical scientists. All were recognized by their contemporaries as moral philosophers, a reputation based on their previously published and internationally well-received works on literary, moral and medical topics. All three physicians published their ethics at the end of their professional lives and consequently, far from being mere 'practical tracts' created in response to a particular event or problem, they are more properly viewed as the distillation of a life-time of medical writing, teaching and practice.[55] Viewed in the wider context of their careers' work as a whole, their theoretical work combines with the practical to illustrate the specific content of an eighteenth-century doctor's duty.

This balance between theory and practice, between character and performance, was adopted self-consciously by our authors as part of the Baconian view of the relationship between science and ethics. Though more or less unrecognized in this context, the Baconian legacy lies at the heart of the doctors' concerns. Bacon approaches the issue by asking a set of questions: Who should write the ethics of a particular profession? Should it be the practitioner himself or should it be a disinterested spectator? What are the advantages of each? Bacon asked these questions early in the seventeenth century and his answers set the terms for the discussion in the eighteenth. This was due to the fact that he put the issue of professional ethics in the wider ambit of man's social duties as a whole.

Bacon argued, first, that 'the good of man which respecteth and beholdeth society', as distinguished from his 'private good', was 'Duty'. This term 'is more proper to a mind well-formed and disposed toward others, as the term of virtue is applied to a mind well-formed and composed in itself'. But a man could no more understand what it meant to be virtuous without first understanding his relation to society than he could understand his duty without first being virtuous. Thus, duty and virtue were inseparable.[56]

For Bacon, man's duty to society was properly divided into two distinct categories. The first was 'the common Duty of every man as a man or member of the state'; and the other, 'the respective or special Duty of every man in his profession, vocation and place'.[57] Bacon's distinction underlines the two types of duties which complete the whole of man's social duties. On this view, a 'general' system of ethics comprised first the duty of man which applied

equally to all men; and second, the various duties which arose from a person's role in society, including that person's office or station in life. Professional ethics, and hence medical ethics, was, in Baconian parlance, a 'respective' or 'special' duty, a usage retained by the three authors at the centre of the present study. 'Respective duty' included

> the duties between husband and wife, parent and child, master and servant; so likewise the laws of friendship and gratitude, the civil bond of companies, colleges and politic bodies, of neighborhoods, and all other proportionate duties; not as they are parts of government and society, but as to the framing of the mind of particular persons.[58]

Bacon's definition of the two types of social duties arose in the context of his discussion in *The Advancement of Learning* regarding who ideally should write a professional ethics or system of duties. General ethics, the first type, was in his estimation 'extant and well laboured', a well-developed field of inquiry, unlike professional ethics, which was 'rather dispersed than deficient'. But this was not in itself a problem. For who *could* single-handedly fulfil the task of describing 'the proper duty, virtue, challenge, and right of every several vocation, profession and place' in society?[59]

According to Bacon, those who proposed that the disinterested lay observer was better qualified to write the ethics of a profession than the practitioner himself, often suggested that 'a looker-on may see more than a gamester'. He disagreed:

> there is small doubt but that men can write best, and most really and materially, in their own professions; and that the writing of speculative men of active matter, for the most part doth seem to men of experience, as Phormio's argument of wars seemed to Hannibal, to be but dreams and dotage.[60]

If the statement of a profession's duties was to be more than mere armchair speculation,

> it would have to be written by men with solid practical knowledge: it were to be wished, as that which would make learning indeed solid and fruitful, that active men would or could become writers.[61]

As a corrective to the professional man's tendency to magnify his own or his profession's importance, Bacon proposed a further necessary qualification. He must not only describe the duties and virtues of his profession, he must also be able to describe its vices.[62] Thus the physician, like Machiavelli, must know and be willing to describe what medical men do as well as what they ought to do. He

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must know the condition of the serpent:

> his baseness and going upon his belly, his volubility and lubricity, his envy and sting, and the rest; that is, all forms and natures of evil: for without this, virtue lieth open and unfenced. An honest man can do no good upon those that are wicked to reclaim them, without the help of the knowledge of evil.[43]

While tales of professional serpents were not lacking, Bacon suggested that this was an argument best handled with 'integrity and truth' and not, as it usually had been, with cynicism and satire.

> for men have rather sought by wit to deride and traduce much of that which is good in professions, than with judgement to discover and sever that which is corrupt. For as Salomon saith, he that cometh to seek after knowledge with a mind to scorn and censure, shall be sure to find matter for his humour, but no matter for his instruction.[44]

Bacon's ideas were the inspiration for most of the Enlightenment programmes for medical reform. They are most prominent in Gregory's *Lectures* where they form the basis of his analysis of the state of medicine. Although Percival and Rush did not parade their colours as explicitly as their predecessor, Bacon was, nonetheless, their acknowledged 'great luminary'.[45] It was in this light that they could see themselves, and be seen by others, as qualified to write their medical ethics because they were, as Bacon had recommended, men who achieved a proper balance between the practical and the speculative or theoretical.

None of these physicians was among the front-ranking philosophers of his time. They were, however, viewed by their contemporaries as excellent practical moralists. Their medical ethics, like much of modern medical ethics, was – *pace* their critics – clearly written for a wider audience than medical students and colleagues. All three were conscious of the distinction between technical or specialized writing and writing which was to be directed to a general audience. Medical ethics was designed for the latter, as well as for medical students and members of the profession. Its aim, like that of all moral philosophy in this tradition, was to persuade, educate and reform. Medical ethics, as part of a system of practical philosophy, was a popular genre accessible to readers of medical literature in general, and it was closely related to the popular domestic and female conduct literature of which John Gregory was one of the century's leading practitioners.

Apart from this commonsense distinction, however, it must be

pointed out that the notion of 'practical' used by the moralists of this period was indeed distinct from 'theoretical'; but it is the meaning of the latter term which most confuses modern readers. The 'theory of morals' in our physicians' tradition of moral philosophy was a branch of the theory of mind, or pneumatology: what, in modern terms, is generally referred to as moral psychology or moral epistemology. By contrast, 'morals', 'ethics' or 'practical ethics' commonly denoted the practical principles, or principles of action, which – as if to defy twentieth-century categories – were organized, more often than not, as virtues and, interchangeably, as duties (and associated rights). Thomas Reid, for example, explained to his Glasgow students that the theoretical part of the science of morals 'was distinct from and subservient to the practical part'.[66] Theories of the moral faculty were seen as highly abstract, infinitely open to dispute and generally having little influence on ordinary moral practice. On the other hand, the rules of moral conduct, such as the specification of appropriate duties, was an eminently practical discipline, accessible to all persons.

The distinction between the theory of the moral faculties and the explanation of duties was an important one in Enlightenment practical ethics and one which had a parallel in contemporary theology. Many clergymen – Scots, Dissenters as well as Latitudinarian Anglicans – argued for the relative simplicity of natural religion which they contrasted with the complicated systems of confessional theologians. As Gregory pointed out in his lectures on religion, the former was accessible to every informed person of sound mind, whereas the latter could only be grasped by the theologian. Just as the arguments of metaphysicians were far too complex to become the foundation for a system of practical duties, so theology was too complex to be used as a guide for religious belief. Just as the natural religious sense, uncontaminated by speculative theology, gave each person an adequate idea of his or her relationship with the Creator, so too, practical ethics, as understood by the moral faculties of ordinary men and women, was sufficient to show us the duty of our station in life. It was the knowledge of these duties that even those who disagreed about the merits of the various philosophical systems could more or less agree upon.[67]

All three of our physicians were, of course, familiar with the 'theory of morals' – Gregory, in fact, *taught* ethics – for they were well aware that their practical ethics presupposed a theory of the moral abilities of the mind. But, with the partial exception of Rush, they plainly had no such theory themselves. On the whole they were

content to accept so broad and vague a concept of the moral faculty that it was compatible both with Butler's and Price's versions of conscience, with a moral-sense theory in the Hutchesonian tradition and with Reidian Common Sense. It simply did not matter, as long as it was understood that the active power was cognitive, educable and potentially authoritative over the passions. As for McCullough's insistence that Gregory's theory of morals was specifically indebted to Hume's notion of sympathy, we will see in the next chapter that this is mistaken.

Medical ethics was clearly part of 'practical ethics'. The doctors were primarily concerned with questions of right and wrong, law and justice, the meaning of the good life, and how one might best prepare oneself for life in the hereafter. As medical moralists, they were, in other words, no more concerned with 'theories of abstract philosophy' (or the problems of moral epistemology) than the contemporary liberal clergy were concerned with intricate systems of theology. Within the moral tradition in which the doctors stand, this issue goes back, most immediately, to Hutcheson and George Turnbull, the former of whom had a famous encounter with David Hume as to whether the philosopher properly should be a moral painter or a moral anatomist. Accusing Hume, the self-declared anatomist, of lacking 'a certain Warmth in the Cause of Virtue' (and easing him out of contention for a professorship in moral philosophy), Hutcheson helped set in train the passion for moral painting that was such a prominent feature of eighteenth-century life.[44]

While the moral faculty in this scheme of things was considered native, it was nevertheless educable, and this is reflected in the importance that practical moralists put upon the preaching, or painting, of morals. Moral exhortation was considered an integral part of the teaching of ethics in both Scottish universities and Dissenting academies. Furthermore, writings on ethics were, as mentioned earlier, aimed at a wide audience because their primary function was public moral education. It is important to appreciate that our three physicians' writings on medical ethics belong to this genre of public moralizing, so much so that the one work that ostensibly has a narrower, more specific aim, Percival's *Medical Ethics*, preserves a large number of features from the morally edifying essay and is, in fact, garnished with several such essays in the form of appendices.

The writings on medical ethics are, in other words, part of the common Enlightenment cultivation of politeness.[45] Politeness and cognate terms such as civility, honour, decorum, urbanity, and

liberality, used by the ethicists, did not merely imply the gentlemanly pursuit of literary style for its own sake. Politeness was also an expression of some of the most important aspects of a programme for both moral and scientific reform. Liberality, sympathy and candour, for example, were the key virtues that distinguished the 'polite' and learned medical scientist from his opposite.[70] For the teachers of medicine from Boerhaave to Rush, this character of the physician was as important to the advancement of medical science as the institution of scientific method. It was inconceivable to them that science could progress unless the scientist-physician himself possessed the requisite moral as well as intellectual virtues. Students of medicine at Edinburgh were taught that the history of their profession was the best reminder of long-recognized flaws in the medical character: its greed, pedantry, disputatious nature and, at times, embarrassing slavishness. Fortunately, however, the past also offered the more positive image: that of a dedicated healer and God's minister to the human body. The Edinburgh ideal of the good physician was an attempt to combine the virtues of the Greek and Christian model. Like Hippocrates, the physician would make his interests subservient to those of his patient and his profession and, as a Christian, subservient to the general good of mankind.

It might be said that in their professional character, the three physicians closely resembled the clergy of the Presbyterian church – Rush the evangelical side, and Gregory and Percival the moderate – who had been their early mentors and, later, university teachers, friends, patients and patrons. Presbyterianism shaped their literary interests and style, their ethical pre-occupations and scientific methodology. Unlike the French *philosophes*, the physicians were not anti-clerical, although they did share a dislike of 'priest-craft' which they identified with 'popery'. Like many of his clergyman friends, Gregory, for example, had some sympathy with the agnosticism and even atheism of the *philosophes* on the grounds that both were understandable responses to Roman Catholicism and the tyrannical government which supported it. But such excuses could not support the atheism and scepticism of British subjects who, he argued, enjoyed the benefits of free inquiry in a reformed Church and a free society. Gregory in particular adopted the polemical terms of the moderate Presbyterian reformers and deployed them for his own critique of medicine.[71]

Practical Ethics

We outlined earlier Robert Baker's notable interpretation of Percival

according to which *Medical Ethics* combined a moral sense theory from Gregory with Thomas Gisborne's notion of implied contract. The former issue was, as we have indicated, of no more than marginal interest to either of the two physicians and received very little concentrated attention in their writings, but Baker makes a curious suggestion about it which has further implications. Baker speculates that Gregory may have received the seeds for his notion of a moral sense from the possible teaching of Christian Thomasius' moral theory in Leyden when Gregory was a student there. The assumption is apparently that Leyden somehow shared, through 'propinquity', in 'the German-language ideal of the virtuous and sentimental physician'.[72] This is curious because Leyden could in no sense be called German, not even by propinquity. It was one of the foremost European centres for Newtonian experimental philosophy;[73] in jurisprudence, the traditional humanistic study of Roman law was dominant, and the only natural law taught was a private class on Pufendorf.[74] Furthermore, by the mid-1740s Thomasius' influence was in sharp decline and no evidence is given to show that Leyden harboured a unique and clandestine pocket of Thomasians.[75] Finally, before Gregory went to Leyden, he is most likely to have been given some basics of 'the theory of morals' from his regent, George Chalmers at King's College in Aberdeen or to have picked up some impressions while studying medicine in Edinburgh.[76] As a stream of scholarship from the last twenty years has shown, the modern, Protestant natural law tradition had had a strong presence in Scotland since the turn of the seventeenth century, first in Glasgow, then in Edinburgh, and soon it was the most pervasive form of academic moral philosophy with repercussions in many quarters outside the academy.[77] The same tradition had been received by English dissenters; and among latitudinarian Anglicans it merged, indistinctly, with a watered-down Thomist tradition deriving from Richard Hooker; and the full spectrum of the tradition was well represented in America. Natural law was, in other words, neither an esoteric doctrine nor as an intellectual souvenir from abroad.

It is against this background that we turn to Baker's re-introduction of Gisborne into the discussion. I fully agree that Gisborne is of importance to our understanding of Percival, and Baker's brief analysis of the central concepts of implied contract and office is quite accurate.[78] But the extraordinary thing is that Baker seems to think that these ideas are original with Gisborne, referring to them as 'the Gisbornian architectonic' without any indication

that they are in fact old – one of them ancient – and that they had enormously wide currency in early modern Europe, not least in the form given them by the Protestant natural lawyers from Samuel Pufendorf onwards and adapted into a variety of British, mainly Scottish moral theories. Baker's whole perspective on eighteenth-century medical ethics in the Anglo-American realm, and especially that of Percival, is thus seriously out of focus and we are deprived of an adequate balance between tradition and innovation in our philosophical doctors. What is significant about their medical ethics is that it attempted to adapt to quite new circumstances a practical ethics that in the end is little more than a systematic articulation of the social ethics of a traditional society. Thomas Gisborne was simply the latest text-book writer in this vein – as well as a good friend and young protégé of Percival's. Gisborne was able and successful – but, then, he did have a very long tradition to draw on. Let us take a brief look at the salient elements of this tradition.

The common *structure* of the systems of practical ethics was provided by the three Christian duties which were elaborated by materials from Stoicism and Roman law. It was an earlier version of this scheme of Christian ethics that Bacon referred to in his critique of medical ethics. Thomas Reid explained it this way:

> Morals [practical ethics] have been methodized in different ways. The ancients commonly arranged them under the four cardinal virtues of Prudence, Temperance, Fortitude and Justice; Christian writers, I think more properly, under the three heads of the Duty we owe to God – to Ourselves – and to our Neighbour. One division may be more comprehensive, or more natural, than another; but the truths arranged are the same, and their evidence the same in all.[79]

Although writers of professional ethics did not adhere rigidly to this structure, they organized their schemes of duties according to these divisions. Consequently, an eighteenth-century physician's duties were divided into those he owed to God, to himself and to others. While modern, secular, medical ethics is only interested in the last, i.e. a physician's duty to others,[80] for Gregory, Percival and Rush the three duties were essentially connected, the basic one being that to God.

Throughout the medical ethics of the Enlightenment, concepts such as 'duty', 'office', 'contract' and 'public good' which signal the influence of Protestant natural law theory are evident. These concepts are, however, somewhat obscure to modern readers. Central to this system of practical ethics is the idea that the public good imposes a set of duties on us and that these duties constitute

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the offices or roles in life we assume. One of the most important sources of this notion of an office was *De officiis* by the ancient eclectic philosopher Cicero, whose version of stoicism had an inestimable influence on moral thought in the Enlightenment. In this book Cicero put forward the basic idea of the link between particular duties and the general duty to the common good, and he questioned the associated relative merits of the various professions and occupations:

> the professions in which either a higher degree of intelligence is required or from which no small benefit to society is derived medicine and architecture, for example, and teaching – these are proper for those whose social position they become.[40]

In the works of Gregory's cousin and mentor, Thomas Reid, we find a Christian elaboration of this idea, one which had become a common assumption of eighteenth-century practical ethics:

> The more important the office is to the well being and happiness of the human kind, so much the more m[c]red are the Obligations to the duties of it But every office & every character has its obligations and every man who takes that office or character upon him takes upon him its obligation at the same time.[41]

In considering this traditional idea of a moral hierarchy of duties and thus of offices, it is important to realize that duties were not only derived from one's office in the sense of one's profession or occupation but also from one's other stations in life; consequently one's offices were interrelated and overlapping. A physician might also be a father, a son, a husband and a master to his servants. Most importantly, one's particular situation or condition, such as wealth, health, age, intelligence or education, imposed duties to serve the common good. Being a medical man was one such special condition.[42]

To take up any office in life, including a vocation or career, was thus a kind of tacit or unwritten contract with one's society to discharge the duties of that office. Each office entailed particular duties which were to be fulfilled as if in accordance with a contract. The contract between a professional man and his society was also one which applied to his relationship with the profession he chose. As Percival explained:

> Every man who enters into a fraternity engages by tacit compact, not only to submit to the laws, but to promote the honour and interest of the association, so far as they are consistent with the general good of mankind.[43]

All duties were reciprocal, and just as a physician had duties to his patients, so too did his patients have duties toward him. Here we might note that while references in early medical ethics to the patient's duties to physicians have surprised some modern critics, it would have been understood by Percival's contemporaries as entirely appropriate. Being sick was for them an office like any other role in life and it too entailed its special duties and responsibilities. Once again we can turn to Thomas Reid for a clear formulation of the contract between patient and physician:

> I apply to a man who professes the healing Art. I tell him that I labour under such an ailment, & desire his advice. He prescribes for me without any more ado. It is evident that he comes under an obligation to prescribe for me according to the best of his skill & I to pay him a reasonable fee though no such thing was expressed on the one hand or the other. The consent to this reciprocal obligation is implyed in the Nature of his Profession my application to him & his prescription for my health.[85]

This, in essence, is the mutual contract between the physician and his patient and the physician and society at large. The common ideas of office, duty and implied contract which we find scattered throughout the medical ethics of this period provide the basic framework for the general social ethics as well as for the 'special' or 'appropriate' ethics implied by a particular office in life.[86] This idea of the implied contract which binds physician and patient together in a moral association that is a small constituent of the common good, is the central point in Enlightenment medical ethics.

Malpractice

The patient–physician contractual relationship described by Thomas Reid was formalized in the eighteenth-century law of malpractice. If, as Reid explained, the primary duty of the physician was the honest exertion of his skills, then this was as if he had promised to the patient to do so. Both understood, moreover, that the non-performance of this duty was a breach of the implied contract. If harm ensued, it was, in law, an actionable breach of duty.

According to William Blackstone, the century's greatest common-law jurist, cases of malpractice could be classified as either battery or trespass or as a breach of contract. In his *Commentaries on the Laws of England*, he explained in language similar to Reid's that there was a class of contracts implied by both natural and civil law and based on the supposition that:

> everyone who undertakes any office, employment, trust or duty, contracts with those who employ or trust him to perform it with integrity, diligence or skill And, if by want of either of those qualities any injury accrues to individuals, they have therefore their remedy in damages by a special action on the case.[47]

The notion of contract, explicated by Reid in its moral aspect and by Blackstone in its legal, found contemporary expression in a famous malpractice case, *Slater* vs. *Baker and Stapleton* (1767). The patient, Slater, claimed that the surgeons, Baker and Stapleton, performed a medical procedure without his consent and despite his protests They had, he argued, 'ignorantly and unskilfully' refractured his broken leg and in the process had injured him. Slater's suit was successfully brought to court under the writ of contract explained above by Blackstone.[48]

Of central importance to *Slater* vs. *Baker* was the emphasis it placed on the notion of customary practice, in this case the custom of surgeons not to operate without the consent of their patients. The court employed a form of reasoning that would characterize the law of malpractice until the twentieth century:

> [I]t appears from the evidence of the surgeons that it was improper to disunite the callous without consent, *this is the usage and law of surgeons*: then it was ignorance and unskillfulness in that very particular, to do contrary to the rule of the profession, what no surgeon ought to have done.[49]

From all of this it will be apparent that another function of medical ethics was to be a systematic guide to customary practice or 'the usage and law' of medical men which could be used in questions of malpractice arising from breach of implied contract. By the same token, as Percival was concerned to note, a medical ethics should be a source of information about medical customs transformed by new developments in medicine and in society. New knowledge and new social opportunities alike implied new duties. Thus Percival's own medical ethics reflects the revolution in medicine brought about by the advent of the voluntary, or charity hospital and, likewise, the dilemmas which arose from the conflict between the demands of a nascent experimental medicine and the physician's duty of benevolence It was, however, within the traditional natural-law and common law framework of duties arising from implied contract that our medical moralists sought to find a balance between custom and innovation

Enlightened Self-Interest

Once we have a clear idea of the kind of moral philosophy our authors worked with, we can make sense of another concept generally misunderstood but central to this tradition, namely that of rational self-interest which was the basis for the Enlightenment's obsession with self-improvement. Like many physicians of their day, Gregory, Percival and Rush vigorously promoted this ideal, and this has been seen as one of the main reasons for their supposed demotion of the moral importance of the physician-patient relationship. The crucial point here, however, is that self-improvement had to be considered a central duty immediately derived from an overriding duty to worship God. In this form of moral theory worship of God consists not least in preservation of and care for his creation. The part of creation that is most immediately our province is our own person, in body and in mind, without which we are unable to discharge our duty to any other part of creation. As Francis Hutcheson explained,

> each one is obliged to cultivate his own powers of body and mind so as to fit himself for what offices of goodness and humanity his station may allow; to store his mind with useful knowledge and with the grand maxims which conduce to a virtuous life [20]

Hence the 'self' referred to in duties to oneself is the Christian one of man as created in the image of God. Self-development for a Christian professional man involved, among other things, the positive duty to cultivate his intellectual abilities or talents in order to promote and secure his best interest and thus be in a position to act his part in society to greater advantage.

The ideal of rational self-interest in the eighteenth century is often confused with a very different philosophy of egoism, and one of the heroes of our three doctors, Bishop Butler, had gone to considerable lengths to distinguish the two, underlining his case by claiming that, if self-interest is properly understood, we need more, not less of it.[21] This was very much the cause of Gregory, Percival and Rush in their opposition to egoism or the so-called selfish systems of philosophy that were commonly identified with Hobbes, Mandeville, Hume and Smith. What the former were concerned with can best be described as a religiously derived duty to self-development.

Manners and Morals

Finally, we are in a position to return to our starting point. As we saw, one of the greatest obstacles to our understanding of

eighteenth-century medical ethics is its constant inclusion of manners with morals, etiquette with ethics.[32] This was not unique to medical ethics; it was in fact the dictionary meaning of ethics and morals. Chambers' *Cyclopedia* defines 'ethics' as, 'the doctrine of manners, or the science of moral philosophy', and 'morals' as 'anything relating to the manners, or conduct of life', while the first *Encyclopaedia Britannica* explains 'moral' as 'something belonging to manners, or the conduct of life'.[33] Our physicians were, however, perfectly able to distinguish between basic and universal duties and derivative and changeable ones. As Gregory explained in his *Lectures*,

> Decorum, decency and propriety are words very undeterminate in their application; for this reason, that the ideas annexed to them are partly founded in nature and common sense, partly in caprice, fashion, and the customs of particular nations. In the first case the obligation to them is immutable, the same in all ages and nations; in the latter it is fluctuating and less binding.[34]

The basic duties between physician and patient were derived from the perennial nature of their respective offices. The duty of secrecy, for example, arose from the physician's privileged access to the patient and his or her family, and from the extreme vulnerability of the patient. All sick persons, rich or poor, young or old, male or female, were owed this duty. What the physician wore when he visited his patients was obviously much more changeable and much less important. The question is, however, why the latter should have been considered a subject in medical ethics at all. The answer is that the physician's dress, like his speech, manners, company, etc., serve to advertise what office a person is discharging and, on the finer points of dress, speech, etc., show with what degree of commitment he is discharging that office.[35] This consideration would have been of greater significance in a much more traditionalist and hierarchical society than ours, but even in a post-modernist society we rely as heavily as ever on conventional indicators – including, certainly, clothes – for what we can expect from whom. And clearly it is by implication possible today, as in the eighteenth century, to lie, deceive and defraud by 'false' dress, speech, manners and the like. As Cicero had already pointed out, adherence to rules of 'mere' decorum are nonetheless essential because they indicate a person who takes account of the specific context of action and who is self-conscious of the office being assumed and the duties it implies. While these factors are absent from today's textbooks in medical

ethics, they have merely been transposed to the criteria for admission to medical schools, to the rules governing the professional bodies sustaining the profession, to the thousands of academic letters of reference written every year.

Genre

As men of letters, the three doctors' most important public attire was, however, their writings, and before entering into closer acquaintance with these, it may be worthwhile to reflect, once more, on their form in the light of the concept of offices. The aim of medical ethics was to portray the role of the medical man and the roles of those with whom he interacted. Since these roles were so broadly conceived, the result was a picture of medical life in its many aspects. We can, accordingly, see the eighteenth-century works in medical ethics as also closely related to two traditional genres, namely the character sketch and the conduct book. The pursuit of ethical ideals through the description of a character-type, or the idealized portrait of a particular character, is one of the oldest forms of moral theorizing. In the form of the highly polished obituary it was crucial to the cohesiveness of the medical profession.[36] Similarly ancient, and equally close to our doctors' hearts, was the conduct book. This genre also had roots in Cicero's *De Officiis*, which was addressed to the author's son as parental advice particularly suited to a young man about to embark on his life's career. The medical ethics of each of our physicians was ostensibly dedicated to young men. In Percival's case the dedicatee was a son about to embark on his medical studies. It is also no coincidence that another of the three physicians, John Gregory, through a book of letters to his daughters, was considered one of the century's leading experts on the conduct of women. Rush, too, saw himself as an expert on the moral conduct of women, and Percival wrote extensively on the moral development of children.[37]

The medical ethics of the three physicians are, in other words, part of a wider concern to analyse the offices and depict the social characters that make up the moral life. And even when practical circumstances made it necessary for Percival to resort to a code of rules, he did not, as we shall see, entirely relinquish the office of moralizing essayist that he shared with his fellow physicians.

Notes

1 Tom L. Beauchamp, Laurence B. McCullough, *Medical Ethics. The Moral Responsibility of Physicians*, New Jersey, 1984, p. 6.

2. Lester S. King, *The Medical World of the Eighteenth Century*, Chicago, 1958. See Chapter VIII, 'The Development of Medical Ethics', pp. 227–61.
3. King, *Medical World*, p. 230.
4. *Ibid.*, p. 232.
5. R.H. Shryock, *Medicine and Society in America. 1660–1860*, New York, 1960, p. 4.
6. C.D. Leake, Preface to Percival's *Medical Ethics*, (1927) second edition, New York, 1975, p. xxx.
7. Leake, Preface, p. 2.
8. It should, though, be noted that Lester King at least acknowledged the historical problem concerning ethics and etiquette. He explained that while many of the problems described by Percival concerning the decorum associated with consultation and the treatment of women seem 'only quaint and archaic' to the modern reader, they nevertheless represented vexing problems for his contemporaries which should not be viewed by historians as 'mere' etiquette. King, *Medical World*, pp. 257–8.
9. Shryock, *Medicine and Society*, p. 26; Chester Burns, 'Thomas Percival, Medical Ethics or Medical Jurisprudence?', in *Legacies in Ethics and Medicine*, ed. Chester Burns, New York, 1977, p. 296. In the most recent discussion of this point, Roy Porter refers to Percival's *Medical Ethics* as a 'practical, shop-floor handbook', 'Thomas Gisborne: Physicians, Christians and Gentlemen', in *Doctors and Ethics: The Earlier Historical Setting of Professional Ethics*, ed. A. Wear, J. Geyer-Kordesch and R. French, Amsterdam, 1993, pp. 252–73. at p. 266.
10. Carleton B. Chapman, *Physicians, Law and Ethics*, New York, 1984, p. 84, quoting *Medical Ethics*, p. 9. Percival's use of the word 'condescension' and the anachronistic interpretation of this passage are taken up by Edmund Pellegrino in his Introduction to Percival, *Medical Ethics*, ed. E. Pellegrino (Classics of Medicine Library), Birmingham, AL, 1985.
11. See for example I. Waddington, *The Medical Profession in the Industrial Revolution*, Dublin, 1984, p. 154; E. Freidson, *Profession of Medicine*, New York, 1972.
12. As we will see in the chapter on Percival, this has led to various distortions of the historical record.
13. Waddington, *The Medical Profession*, p. 171. See in a similar vein David J. Rothman, 'Human Experimentation and the Origins of Bioethics in the United States', in *Social Science Perspectives in Medical Ethics*, ed. George Weisz, Philadelphia, 1990, p. 185: 'the ethical tracts of Anglo-American doctors seem most remarkable for elevating medical etiquette over medical ethics, for moving ever so nimbly from the high minded injunction – do no harm – to practical, professionally self-serving maxims – do not slander a fellow

doctor or pay social visits to his patients or contradict him in front of his patients. In this literature, coveting a colleague's patients appears as a far more serious breach than coveting his wife. But the distinction between etiquette and ethics hardly mattered to the tracts' authors or audience of practicing physicians. These were not exercises in philosophical discourse but manuals for the man in the field who was equally intent on doing well by his patient and doing well by his practice.'

14. John Pickstone, 'Thomas Percival and the Production of *Medical Ethics*', in *The Codification of Medical Morality*, ed. Baker, Porter and Porter, pp. 161–78.
15. Jeffrey Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* Berkeley, CA, 1975; Ivan Waddington, 'The Development of Medical Ethics – a Sociological Analysis', *Medical History*, 19 (1975): 36–51, same, *The Medical Profession in the Industrial Revolution.*
16. Berlant, *Profession and Monopoly*, p. 84.
17. The first code of the AMA appeared in 1847. Laurence B. McCullough, 'Virtues, Etiquette and Anglo-American Medical Ethics in the Eighteenth and Nineteenth Centuries', in *Virtues and Medicine: Explorations in the Character of Medicine*, ed. Earl E. Shelp, Dordrecht and Boston, 1985, p. 89.
18. Berlant, *Profession and Monopoly*, pp. 149–50.
19. *Ibid.*, pp. 93–5.
20. See for example McCullough, 'Virtues, Etiquette', p. 89; Carleton B. Chapman, *Physicians, Law and Ethics*, New York, 1984, pp. 76–88 (to be discussed below), Rothman, 'Human Experimentation and the Origins of Bioethics in the United States', in *Social Science Perspectives in Medical Ethics*, ed. G. Weisz, Philadelphia, 1990, pp. 183–200
21. Laurence B. McCullough, 'Medical Ethics, History of: Modern Period: Seventeenth to the Nineteenth Century, Britain and the U.S. in the Eighteenth Century', in *Encyclopedia of Bioethics*, ed. Warren T. Reich, New York, 1978, pp. 957–63; *idem*, 'Historical Perspectives on the Ethical Dimensions of the Patient–Physician Relationship: The Medical Ethics of Dr. John Gregory', *Ethics in Science and Medicine*, 5 (1978): 47–53; *idem*, 'Virtues, Etiquette'; 'The Legacy of Modern Anglo-American Medical Ethics: Correcting Some Misperceptions', in *The Clinical Encounter*, ed. Earl E. Shelp, Dordrecht, 1983, pp. 47–63; and 'John Gregory's Medical Ethics and Humean Sympathy', in *The Codification of Ethics*, ed. Baker, Porter and Porter, pp. 145–60.
22. McCullough, 'Virtues, Etiquette', p. 82. In his most recent paper, 'John Gregory's Medical Ethics', McCullough goes into more detail about the concept of sympathy. We will consider this below in Chapter 2.
23. McCullough, 'Virtues, Etiquette', p. 85

24. *Ibid.*, p. 89
25 *Ibid.*, p. 89.
26. Carleton B. Chapman, *Physicians, Law and Ethics*, pp. 76–88.
27 Thomas Gisborne, *An Enquiry into the Duties of Men in the Higher and Middle Classes of Society in Great Britain, Resulting from their Respective Stations, Professions, and Employments*, 2 vols, London, 1794. See particularly chap. 12 (pp. 383–426) 'On the Duties of Physicians'.
28 Gisborne, *Duties of Men*, p. 396. Quoted in Chapman, *Physicians, Law and Ethics*, p. 81.
29 Chapman, *Physicians, Law and Ethics*, p. 83. See also Roy Porter's exegesis of the constitution of eighteenth-century medical ethics as it appears in Gisborne; 'Thomas Gisborne: Physicians, Christians and Gentlemen'. Porter here contrasts what he describes as Percival's 'anodyne' treatment of the subject with that of Gisborne which he sees as a more searching analysis of the mercenariness of the sick trade'
30. Robert Baker, 'Deciphering Percival's Code', in *The Codification of Medical Morality*, ed. Baker, Porter and Porter, pp. 179–212
31 Baker, 'Deciphering Percival's Code', especially pp. 193ff., Lisbeth M. Haakonssen, 'The Duties of an Eighteenth-Century Physician. The Medical Ethics of John Gregory, Thomas Percival and Benjamin Rush', Ph.D. thesis, Australian National University, 1993, chap. 3.
32 *Ibid.*, pp. 194–6.
33. *Ibid.*, pp. 193–4. My summary of Percival's Gisbornian revolution relates to pp. 197–208.
34. See J.G.A. Pocock, 'Clergy and commerce: The conservative Enlightenment in England', in *L'Età dei Lumi. studi storici sul settecento europeo in onore di Franco Venturi*, ed. Ajello *et al.*, 2 vols, Naples, 1985, vol. 2, pp. 23–68; *idem*, 'Conservative Enlightenment and democratic revolutions: The American and French cases in British perspective', *Government and Opposition*, 24 (1989), 81–105; *idem*, 'Josiah Tucker on Burke, Locke, and Price: A study in the varieties of eighteenth-century conservatism', in Pocock, *Virtue, Commerce, and History. Essays on Political Thought and History, Chiefly in the Eighteenth Century*, Cambridge, 1985, pp. 157–91
35 See J.G.A. Pocock, 'Post-puritan England and the problem of the Enlightenment', in *Culture and Politics from Puritanism to the Enlightenment*, ed. P. Zagorin, Berkeley, CA, 1980, pp. 91–111; *idem*, 'Clergy and commerce: The conservative Enlightenment in England', in *L'Età dei Lumi: studi storici sul settecento europeo in onore di Franco Venturi*, ed. Ajello *et al.*, 2 vols, Naples, 1985, vol. 2, pp. 23–68, *idem*, 'Conservative Enlightenment and democratic revolutions: The American and French cases in British perspective', *Government and Opposition*, 24 (1989), 81–105; *idem*, 'Josiah Tucker on Burke, Locke, and Price: A study in the varieties of eighteenth-

century conservatism', in Pocock, *Virtue, Commerce, and History. Essays on Political Thought and History, Chiefly in the Eighteenth Century*, Cambridge, 1985, pp. 157–91.[35]

36. A series of letters from Percival to Rush can be found in the Rush Manuscripts in The Library Company of Philadelphia.
37. See L. Rosner, *Medical Education in the Age of Improvement. Edinburgh Students and Apprentices 1760–1826*, Edinburgh, 1991. For a more general account, see D. Hamilton, *The Healers: A History of Medicine in Scotland*, Edinburgh, 1981. See also J. B. Morrell, 'Medicine and Science in the Eighteenth Century', in *Four Centuries. Edinburgh University Life 1583–1983*, ed. G. Donaldson, Edinburgh, 1983, pp. 38–52.
38. On the early influence of Newton's ideas in Scotland, see Lester S. King, *The Philosophy of Medicine: The Eighteenth Century*, Cambridge, MA, 1978; Anita Guerrini, 'Isaac Newton, George Cheyne and the *Principia Medicinae*', in *The Medical Revolution of the Seventeenth Century*, eds. Roger French and Andrew Wear, Cambridge, 1989, pp. 222–45. For a helpful discussion of Boerhaave's system, see Lester S. King, *The Medical World of the Eighteenth Century*, Chicago, 1958, pp. 59–93.
39. See Andrew Cunningham, 'Medicine to calm the mind: Boerhaave's medical system and why it was adopted in Edinburgh', in *The Medical Enlightenment of the Eighteenth Century*, eds. Andrew Cunningham and Roger French, Cambridge, 1990, pp. 40–67.
40. See especially John Gregory, *Lectures on the Duties and Qualifications of a Physician*, London, 1772, pp. 183–6, and Rush's lecture 'On the Opinions and Modes of Practice of Hippocrates' (1806) in *Sixteen Introductory Lectures to Courses of Lectures upon the Institutes and Practice of Medicine ...*, Philadelphia, 1811, pp. 274–94.
41. While there is no evidence in the work of our three physicians that the Hippocratic oath *per se* played a key role in their moral deliberations, Edinburgh graduates did swear an oath that they 'would never wantonly experiment' with their patients or divulge anything told to them in secret. See Christopher Lawrence, 'Medicine as Culture: Edinburgh and the Scottish Enlightenment', Ph.D., University of London, 1984, p. 200. Significantly, Michael Ryan, an early nineteenth-century London physician, noted that Edinburgh was the only university or college which required its graduates to swear such an oath. See Michael Ryan, *A Manual of Medical Jurisprudence*, London, 1840, p. 9.
42. See Percival, *Medical Ethics, or, A Code of Institutes and Precepts adapted to the Professional conduct of Physicians and Surgeons, to which is added an Appendix containing A Discourse on Hospital Duties: Also Notes and Illustrations*, Manchester, 1803, chap. 3, art. 1. Unlike Gregory, Percival also addressed his work to physicians and surgeons alike. Cf. Gregory, *Lectures*, pp. 231–33.

43. See especially J.B. Morrell, 'The University of Edinburgh in the Late Eighteenth Century: Its scientific eminence and academic structure', *Isis*, 62 (1970), 158–71; John R.R. Christie, 'Edinburgh Medicine in the Eighteenth Century: The View from the Students', *The Bulletin of the Society for the Social History of Medicine*, 19 (1976), 13–15.
44. Hamilton, *The Healers*, p. 142. See also Roy Porter, 'Plutus or Hygeia? Thomas Beddoes and the Crisis of Medical Ethics in Britain at the Turn of the Nineteenth Century', in *The Codification of Medical Morality. Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Centuries*, vol. 1: *Medical Ethics and Etiquette in the Eighteenth Century*, ed. R. Baker, D. Porter and R. Porter, Dordrecht, 1993, pp. 73–91.
45. Gregory, *Lectures*, pp. 4–5.
46. See *Autobiography of Benjamin Rush: His Travels Through Life, Together with His Common Place Book for 1789–1813*, ed. G.W. Corner, Princeton, NJ, 1948, p. 108.
47. *Autobiography of Rush*, pp. 108–9.
48. Gilbert Blane, 'Address to the Medical Society of Students at Edinburgh, upon Laying the Foundation of their Hall', in *History of the Royal Medical Society 1737–1937*, ed. J. Gray, Edinburgh, 1952, p. 30.
49. Gregory, *Lectures*, p. 212.
50. See W.J. Bell, 'Some American Students of "That shining oracle of physic", Dr William Cullen of Edinburgh, 1755–1766', in *Proceedings of the American Philosophical Society*, 94 (1950), 275–81.
51. The best account of the origins of the Scottish learned societies is Roger Emerson, 'Sir Robert Sibbald, The Royal Society of Scotland, and the Origins of the Scottish Enlightenment', *Annals of Science*, 45 (1988), 41–72. Also Davis D. McElroy, *Scotland's Age of Improvement: A Survey of Eighteenth-Century Literary Clubs and Societies*, Pullman, 1969; H. Lewis Ulman (ed.), *The Minutes of the Aberdeen Philosophical Society (1758–1773)*, Aberdeen, 1990; Paul Wood, 'Science and the Aberdeen enlightenment', in *Philosophy and Science in the Scottish Enlightenment*, ed. P. Jones, Edinburgh, 1988, pp. 39–66.
52. Rush was perhaps not as clubable as his British counterparts, but he nevertheless believed that unless medical men socialized in an organized manner, they would remain enemies of each other. His own life, he noted ruefully, illustrated the truth of John Gregory's remark that 'nothing could exceed the malice of rival authors except the rancour of rival physicians'. *The Letters of Benjamin Rush*, ed. L.H. Butterfield, 2 vols, Princeton, NJ, 1951, vol. 2, p. 1069.
53. For the role of patronage in the development of early modern medicine, see Roger Emerson, 'Medical Men, Politicians and the Medical Schools at Glasgow and Edinburgh 1685–1803', in *William*

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Cullen and the Eighteenth-Century Medical World, eds A. Doig *et al.*, Edinburgh, 1993, pp. 186–216.

54. Cf. R.H. Girdiwood, 'The Influence of Scotland on North American Medicine', in *The Influence of Scottish Medicine: An Historical Assessment of Its International Impact*, ed. D.A. Dow, Carnforth, 1988, pp. 31–42.
55. Maureen McNeil, *Under the Banner of Science. Erasmus Darwin and his Age*, Manchester, 1987, p. 125.
56. This is my only reservation about John Pickstone's fine analysis of the background to *Medical Ethics*. He links the work so closely to the situation at the Manchester Hospital in the 1790s that the depths of its roots both in Percival's work as a whole and in the moral-medical tradition are lost sight of. See John Pickstone, 'Thomas Percival and the Production of *Medical Ethics*', in *Codification of Medical Morality*, ed. Baker, Porter and Porter, pp. 161–78.
57. Francis Bacon, *The Advancement of Learning*, ed. and introd. by G.W. Kitchin, London, 1965, Book II, p. 63 (6).
58. *Ibid.*, p. 163 (7).
59. *Ibid.*, p. 166 (10–11).
60. *Ibid.*, p. 163 (7). Later, in the eighteenth century, Thomas Gisborne, among many others, took up the challenge, as we have noted, with his monumental and extremely popular *An Enquiry into the Duties of Men*. He followed this up with a companion volume for women, *Inquiry into the Duties of the Female Sex*, London, 1797.
61. *Ibid.*, p. 163 (7). He is referring to Cicero's *De Oratore*, II.18.75.
62. *Ibid.*, p. 163 (7).
63. *Ibid.*, p. 165 (9).
64. *Ibid.*, p. 165 (9).
65. *Ibid.*, p. 165 (9).
66. Percival, *Medical Ethics*, p. 96.
67. See Thomas Reid, *Practical Ethics. Being Lectures and Papers on Natural Religion, Self-Government, Natural Law and the Law of Nations*, ed. and introd. by K. Haakonssen, Princeton, NJ, 1990, p. 111. And cf. Adam Smith, *The Theory of Moral Sentiments*, ed. D.D. Raphael and A.L. Macfie, Oxford, 1976, VII.i.2–4 and iii.1–3.
68. For a typical discussion of this problem as it was taught in the dissenting academies, see John Prior Estlin, *Familiar Lectures on Moral Philosophy*, 2 vols, London, 1818, pp. 62–74.
69. For the exchange between Hume and Hutcheson, see *Letters of David Hume*, ed. J.Y.T. Greig, 2 vols, Oxford, 1932, vol. 1, p. 32. For Hutcheson and Turnbull, see K. Haakonssen, *Natural Law and Moral Philosophy: From Grotius to the Scottish Enlightenment*, Cambridge, 1995, chapter 2; M.A. Stewart, 'George Turnbull and Educational Reform', in *Aberdeen and the Enlightenment*, eds. J.J. Carter and J.H. Pittock, Aberdeen, 1987, pp. 95–103.
70. The work of Nicholas Phillipson and John Dwyer on politeness and

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the Scottish Enlightenment is particularly useful here. See especially Phillipson, 'Adam Smith as Civic Moralist', in *Wealth and Virtue: The Shaping of Political Economy in the Scottish Enlightenment*, eds. I. Hont and M. Ignatieff, Cambridge, 1983, pp. 179–202; 'Culture and Society in the Eighteenth-Century Province: The Case of Edinburgh and the Scottish Enlightenment', in *The University in Society*, ed. L. Stone, 2 vols, Princeton, 1974, II: 407–48; 'The Pursuit of Virtue in Scottish University Education: Dugald Stewart and Scottish Moral Philosophy in the Enlightenment', in *Universities, Society and the Future*, ed. N. Phillipson, Edinburgh, 1983, pp. 82–101; 'The Scottish Enlightenment', in *The Enlightenment in National Context*, ed. R. Porter and M. Teich, Cambridge, 1981, pp. 19–40; 'Towards a Definition of the Scottish Enlightenment', in *City and Society*, ed. P. Fritz and D. Williams, Toronto, 1973, pp. 125–47. For Dwyer, see 'Clio and Ethics: Practical Morality in Enlightened Scotland', *The Eighteenth Century*, 30 (1989); 45–72; 'Enlightened Spectators and Classical Moralists: Sympathetic Relations in Eighteenth-Century Scotland', in *Sociability and Society in Eighteenth-Century Scotland*, eds. J. Dwyer and R.B. Sher, Edinburgh, 1993, pp. 96–118; *Virtuous Discourse: Sensibility and Community in Late Eighteenth-Century Scotland*, Edinburgh, 1987. The following works provide further perspectives on this issue: Ann Jessie Van Sant, *Eighteenth-Century Sensibility and the Novel: The Senses in Social Context*, Cambridge, 1994; Christopher Lawrence, 'The Nervous System and Society in the Scottish Enlightenment', in *Natural Order: Historical Studies of Scientific Culture*, eds. Barry Barnes and Steven Shapin, London, 1979, pp. 19–40; John Mullan, *Sentiment and Sociability: The Language of Feeling in the Eighteenth Century*, Oxford, 1988.

71. Cf. Roger Emerson, 'Science and the Origins and Concerns of the Scottish Enlightenment', *History of Science*, 26 (1988), 364.
72. For Gregory's views on religion and philosophy, see *Lectures*, pp. 65–70.
73. Robert Baker, Introduction to part 2, 'The Eighteenth-Century Philosophical Background', in *The Codification of Medical Morality*, ed. Baker, Porter and Porter, pp. 93–8 at 97–8.
74. Gregory missed the real heroes, Boerhaave and s'Gravesande, who had died in 1738 and 1742, respectively. Baker rightly says that we do not know which lectures Gregory attended; but his friend and fellow-student, Alexander Carlyle, assures us that he attended very few: 'I ask'd Gregory why he Did not attend the Lectures, which he answer'd by asking in his turn why I Did not attend the Divinity Professors ... Having heard all they could say in much better form at home, we went but rarely and for Form's Sake only to Hear the Dutchmen.' Alexander Carlyle, *Anecdotes and Characters of the Times*, ed. James Kinsley, London, 1973, p. 89. Being concerned with 'Form', Gregory presumably heard Petrus van Musschenbroek on a

few occasions and, as I hope to show in future work, he seems to have remembered something from Jerome Gaub. For Newtonianism at Leyden, see for example Ernst Cassirer, *Philosophy of the Enlightenment*, Princeton, NJ, 1979, pp. 60–4.

75. See R. Feenstra and C.J.D. Waal, *Seventeenth-Century Leyden Law Professors and their Influence on the Development of the Civil Law. A Study of Bronchorst, Vinnius and Voet*, Amsterdam and Oxford, 1975; Wyger R.E. Velema, *Enlightenment and Conservatism in the Dutch Republic. The Political Thought of Elie Luzac (1721–1796)*, Assen, 1993, pp. 82–5.
76. For Thomasius and the Thomasian school, see Knud Haakonssen, 'Natural Law and the German Tradition', in *Cambridge History of Eighteenth-Century Political Thought*, ed. Mark Goldie and Robert Wokler, Cambridge, forthcoming, and the wider literature cited there.
77. In fact, Baker's suggestion is made in order to account for the inclusion in the volume in question of an interesting paper on Thomasius by Johanna Geyer-Kordesch, 'Natural Law and Medical Ethics in the Eighteenth Century', *Codification of Medical Morality*, pp. 123–39.
78. See, for example, Duncan Forbes, 'Natural Law and the Scottish Enlightenment', in *The Origins and Nature of the Scottish Enlightenment*, ed. R.H. Campbell and A.S. Skinner, Edinburgh, 1982, pp. 186–204; Knud Haakonssen, *Natural Law and Moral Philosophy: From Grotius to the Scottish Enlightenment*, Cambridge, 1995 (with extensive bibliography); *idem*, 'Introduction', in Thomas Reid, *Practical Ethics. Being Lectures and Papers on Natural Religion, Self-Government, Natural Jurisprudence and the Law of Nations*, ed. K. Haakonssen, Princeton, NJ, 1990; *idem*, 'Natural Jurisprudence in the Scottish Enlightenment: Summary of an Interpretation', in *Enlightenment, Rights and Revolution*, ed. Neil MacCormick and Zenon Bankowski, Aberdeen, 1989, pp. 36–49; Istvan Hont and Michael Ignatieff, 'Needs and Justice in the *Wealth of Nations*', in *Wealth and Virtue*, ed. Hont and Ignatieff, pp. 1–44; D.N. MacCormick, 'Adam Smith and Law', in *Valparaiso University Law Review*, 15 (1981), 243–63; Thomas Mautner, 'Pufendorf and Eighteenth-Century Scottish Philosophy', in *Samuel von Pufendorf (1632–1982)*, ed. K.A. Modéer, Stockholm, 1986, pp. 120–31; James Moore and Michael Silverthorne, 'Gershom Carmichael and the Natural Jurisprudence Tradition in Eighteenth-Century Scotland', in *Wealth and Virtue*, pp. 73–85; *idem*, 'Natural Sociability and Natural Rights in the Moral Philosophy of Gershom Carmichael', in *Philosophers of the Scottish Enlightenment*, ed. V. Hope, Edinburgh, 1984, pp. 1–12; James Moore, 'The Two Systems of Francis Hutcheson: On the Origins of the Scottish Enlightenment', in *Studies in the Philosophy of the Scottish Enlightenment*, ed. M.A. Stewart,

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